Exhibit 10-1

RxAmerica Prior Authorization Request

Date: _____

Patient's name: _____

Patient's AHCCCS ID number: _____

Physician's name _____

Physician's phone number: ( ) _____

Physician's fax number: ( ) _____

Drug and dose requested: _____

Formulary agents already tried: _____

_____

_____

Rationale for request: _____

_____

_____

Please provide copy of chart notes.

FAX request to *RxAmerica* at (888) 465-9889 or (888) 994-4994

FOR OFFICE USE ONLY

Approved ☐ Denied ☐ Pending ☐

Rationale: _____

Received: _____ Physician Notified: _____